

Registration District No. 677

Primary Registration District No. 5901

State File No.

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Rural
(c) Name of hospital or institution: Route 2
(d) Length of stay: In hospital or institution. (Specify whether)
In this community 2 years, months or days

3. (a) PRINT FULL NAME

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March 8, 1885

8. AGE: Years 55 Months 8 Days 4 If less than one day hr. min.

9. Birthplace Phelps Co. Mo.

10. Usual occupation Home

11. Industry or business

12. Name L. S. Haggins

13. Birthplace Va.

14. Maiden name Sarah S. Haggins

15. Birthplace Marion Co. Mo.

16. (a) Informant Bessie Haggins

(b) Address Route 2

17. (a) Rural (b) Date thereof Nov. 14, 1940

(c) Place: burial or cremation Springbrook Cem

18. (a) Signature of funeral director Fuller

(b) Address Route 2

19. (a) Nov. 14, 1940 (b) Joe F. Myers

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town Rural
(d) Street No. Route 2
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12 year 1940 hour 10 minute P M.

21. I hereby certify that I attended the deceased from 9-13-40 to 11-12-40

that I last saw her alive on 11-12-40 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Congestive Heart

Due to Uremia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature H. H. Davis M.D. (M. D. or other)

Address Rolla Mo. Date signed 11/13/40

922

NOV 25 1921

RECEIVED
District Health Officer No. 5,
District File Number 1240/221
Date Filed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed S. L. V. Jones
Licensed Embalmer No. 3397
P. O. Address Rolla Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)
If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43504

Registration District No. 677

Primary Registration District No. 5901

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Phelps
(b) City or town Rolla T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether

In this community
years, months or days)

3. (a) PRINT
FULL NAME

Claudia Goggin

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex

7

5. Color or

race W

6. (a) Single, widowed, married,

divorced 8

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if

alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

55

8

4

hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____

- (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____

- (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____

(If outside city or town limits write "RURAL")

- (d) Street No. _____

(If rural, give location)

- (e) If foreign born, how long in U. S. A.?

years _____

20. DATE OF DEATH Month Nov day 12
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19 _____, to _____ 19 _____;

that I last saw him alive on _____ 19 _____;

and that death occurred on the date and hour stated above.

Immediate cause of death myo Carditis Duration _____

Due to congestive heart

left Nephritis

Due to uremia

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____

(City or town)

(County)

(State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature H. H. Davis (M. D. or other) _____

Address Rolla Mo Date signed _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

S-43504